

**Centers for Medicare & Medicaid Services (CMS)**  
**Workers' Compensation (WC)**  
**Medicare Set-aside Proposal**  
**Requirements Checklist**

Please mail or fax **only** the item(s) indicated below no later than 30 days from the date of this document. Information provided on a CD-ROM must be in PDF format and in the same order as requested below. All documents on the CD-ROM must be identified on an index. Medical records must be submitted in a logical order. Requested information may be mailed to:

CMS  
c/o Coordination of Benefits Contractor  
P.O. Box 660  
New York, NY 10274-0660

Attention: WCMSA Proposal

The requested information may also be faxed to **(646) 458-6745**, however, the fax is limited to **10 pages maximum**. If you are faxing the documentation, please include the CMS Case Control Number on the bottom of each page. Please keep in mind this fax number is **NOT** for initial WCMSA submissions, only for additional documentation.

**1. A cover letter must include the following information for all Medicare Set-aside arrangement proposals.**

- Claimant's Name
- Claimant's Date of Birth
- Claimant's Health Insurance Claim Number (HICN) or Social Security Number (SSN) if claimant is not yet entitled to Medicare
- Claimant's Address and Phone Number – The address is used primarily for (1) mailing copies of CMS correspondence and (2) for information purposes when the claimant is also the Administrator of the set-aside account.
- Claimant's Release – claimant's signed authorization for CMS, its agents and/or contractors to discuss his or her case/medical condition with parties to a WC settlement that includes a Medicare Set-aside arrangement (sample format attached).
- Claimant's Counsel: Name, address and telephone number
- Entitlement Information – Indicate if the claimant is currently enrolled in Part "A" and Part "B" of Medicare or in Part "A" only.

When the claimant is not currently enrolled in Medicare Part A or Part B, indicate if any of the following situations apply to the claimant or if another situation will result in the claimant being enrolled in Medicare within 30 months of the date of settlement.

- ☐ Individual has applied for Social Security Disability Benefits (SSDB)
- ☐ Individual has been denied SSDB but anticipates an appeal
- ☐ Individual is in process of appealing and/or re-filing for SSDB
- ☐ Individual is 62 years and 6 months old
- ☐ Individual has End Stage Renal Disease (ESRD) but does not yet qualify for Medicare based on ESRD
- ☐ Other (explain)

- Employer's Information – name, address and phone number
- WC Insurer – name, address and phone number of employer's insurance company
- State of Venue—name of state where WC hearing is being held.
- Attorney Representing Employer or WC Insurer - name, address and phone number if employer's or WC Insurer's attorney has prepared documentation for the Medicare Set-aside arrangement.
- Injury/Disease Date – the date the injury(ies) occurred.
- Type of Injury/Disease – a brief description of the work-related injuries sustained including the ICD-9 diagnosis codes, if available.
- Total WC Settlement Amount - including the Medicare Set-aside amount plus the amount provided for all other aspects of the settlement.
- Proposed Medicare Set-aside Amount - proposed amount to be placed in a Set-aside arrangement for future items/services that would otherwise be paid by Medicare.

## **2. Documentation that must be available to CMS prior to the approval of a Medicare set-aside arrangement**

- Life Expectancy – Provide an evaluation of whether the claimant's condition would shorten the life span or a copy of State law that specifically limits the length of time that WC covers work-related conditions. If a rated age obtained from life insurance companies for like injuries/illnesses is the method of evaluation, include documentation to support the life expectancy. CMS will project the cost of the claimant's future treatment over the claimant's life expectancy using the most recent table listed on the Centers for Disease Control website (<http://www.cdc.gov/nchs/products/pubs/pubd/lftbls/life/1966.htm>), unless documentation from a medical professional provides justification for an alternative projection.
- Life Care Plan – A life care plan is appropriate when the claimant's injury/disease is extensive/serious, e.g., paraplegia, quadriplegia, brain damage.

- Proposed WC Settlement Agreement - Provide a copy of the proposed settlement agreement.
- Current Treatment – Provide the treatment/services that the claimant regularly receives. The current treatment should give an indication that the work-related condition is stable. The summary of current treatment should be supported by a minimum of two years of medical documentation and a comprehensive payment history from the WC Carrier (including indemnity payments). If the work-related injury occurred less than two years from the date of submission of the WC Medicare Set-aside arrangement, supporting medical documentation should date back to the date of the work-related injury. Also note any relevant past treatment, such as surgery, that the claimant may have undergone.

In addition, the summary of current treatment should be supported by a minimum of two years of prescription drug information that is related to the WC injury and/or illness/disease. Include the name of the drug, dosage, and intake regimen (i.e. 3 times a day, once a month etc.) for each drug listed.

Also, provide a comprehensive payment history from the WC Carrier as follows:

- If the injury occurred less than 2 years from the date of the submission, the prescription drug payment history should include those payments that were paid from the injury date through the date of submission.
- If the injury occurred more than 2 years from the date of the submission, the prescription drug payment history should include the last 2 years of payments for prescription drugs.
- Future Treatment – Identify specific types of medical services/items, the frequency/duration of the medical services/items and the projected costs of the medical services/items related to the work injury/disease that are expected in the future in light of the claimant's condition. Include ICD-9 diagnosis codes if available. Appropriately identify the information by both Medicare covered services and services not covered by Medicare. Future treatment must be based on the evaluation and recommendation of a physician(s), e.g., the primary care physician, orthopedic surgeon or other specialist (if applicable). An Independent Medical Examination (IME) may be sufficient under certain circumstances, e.g., claimant has not received treatment in several years and there is no primary care physician. The claimant's condition and medical care required in the future must be documented in written evaluations, reports and/or letters from a physician(s). Living arrangements that impact the medical benefits of the settlement should be noted.

Example: The primary care physician states that during the claimant's life expectancy of 30 years, it is estimated that he/she will need the following Medicare covered services.

- A physician visit every 6 months with an estimated cost of \$75 per visit.
- Physical therapy (PT) - 12 sessions per year for only the next 3 years with estimated cost of \$50 per session
- An x-ray every 3 years with an estimated cost of \$100 per x-ray (including interpretation)

- An MRI every 5 years with an estimated cost of \$1,500 per MRI (including interpretation)
- Inpatient hospitalization every 10 years with an estimated cost \$10,000 per hospitalization

The projected total costs in this case are \$46,300 as listed below.

- Physician visits @ \$4,500 (\$75 x 2 x 30)
  - PT @ \$1,800 (\$50 x 12 x 3)
  - X-rays @ \$1,000 (\$100 x 10)
  - MRIs @ \$9,000 (\$1,500 x 6)
  - Hospitalizations @ \$30,000 (\$10,000 x 3)
- Future Prescription Drug Information – Provide a list of prescription drugs related to the WC injury and/or illness/disease that the claimant will need to take in the future. Include the name of the drug, dosage, and intake regimen (i.e. 3 times a day, once a month etc.) for each drug listed that is covered by Medicare.
  - Patient Medical Recovery Prognosis – Describe the expected recovery, e.g., full or partial. Describe the projected recovery period. Identify the date at which the patient achieved maximum medical improvement (when relevant).
  - Total Settlement Amount – Provide the **total** WC settlement amount and NOT the settlement amount minus attorney fees, expenses, etc. Identify all categories of the settlement.
  - Amount for Future Medical Treatment – Identify the total amount of the WC settlement that is designated for future medical benefits (separate from wage/indemnity benefits). If the settlement does not specify a total amount for future medical treatment, explain why it does not. Identify separately the appropriate future expenses that might otherwise be paid by Medicare.
  - Identify the calculation method used to determine the amount for future medical treatment, **WC fee schedule** or **full actual charges**. Identify if the amount is for the claimant's lifetime or for a specified time period.
  - Medicare Set-aside Amount – State the amount of the medical benefits that you propose to be placed in the Medicare Set-aside arrangement for future items/services that would otherwise be covered by Medicare. Include a payout schedule for each year if a structured settlement is applicable. Outline future non-Medicare covered expenses not included in the Medicare Set-aside. amount, e.g., fitness center memberships.
  - Administrator – Designate the administrator responsible for control and documentation of proper expenditures from the Medicare Set-aside account. Include the address of the administrator if it is not the claimant.
  - Medicare Set-aside Arrangement Account - The arrangement may be funded with a lump-sum amount or a structured annual amount or a combination of both. Funds must be placed in an interest-bearing account. If an account is structured and funded by an annual annuity, identify the source of the annuity and include the annual

payment amount, annual funding date, and the amount of the initial lump sum deposit.

- Fees - One-time and recurrent administrative fees/expenses for administration of the Medicare Set-aside arrangement and/or attorney costs specifically associated with establishing the Medicare Set-aside arrangement cannot be charged to the set-aside arrangement. The payment of these costs must come from some other payment source that is completely separate from the Medicare Set-aside arrangement funds.
- Final WC Settlement Agreement - Approval of the WC Medicare Set-aside arrangement is not final until CMS receives an executed copy of the final settlement agreement that has been approved and signed by all parties. Forward a copy of the final settlement agreement to:

CMS  
c/o Coordination of Benefits Contractor  
P.O. Box 660  
New York, NY 10274-0660

Attention: WCMSA

**CONSENT TO RELEASE FORM**CMS Case Control Number: CASENUM

The Privacy Act of 1974 (Public Law 93-579) prohibits the government from revealing information from personal files without the express written permission of the person involved. Disclosure of personal records to an attorney or other representative who is acting on behalf of another person is prohibited, unless the individual to whom the record pertains has consented.

I, \_\_\_\_\_, hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to disclose, discuss, and/or release, orally or in writing, information related to my workers' compensation injury and/or settlement to the individual(s) and/or firm(s) listed below. This consent is for my current workers' compensation claim and is on an ongoing basis. An additional consent to release form will not be necessary unless or until I revoke this authorization (which must be in writing).

PLEASE CHECK:

- ☐ Claimant's attorney \_\_\_\_\_  
(name and/or firm)
- ☐ Employer's attorney \_\_\_\_\_  
(name and/or firm)
- ☐ Workers' compensation carrier \_\_\_\_\_  
(name and/or firm)
- ☐ Other \_\_\_\_\_  
(name and/or firm)

\_\_\_\_\_  
Claimant's Signature\_\_\_\_\_  
Date Signed\_\_\_\_\_  
Date of Injury\_\_\_\_\_  
Social Security Number Or  
Health Insurance Claim Number

